HOUSE BILL No. 1749

DIGEST OF INTRODUCED BILL

Citations Affected: IC 2-5-23; IC 5-10-8-8.1; IC 27-8; IC 27-13-16-4; IC 34-30-2-116; IC 34-30-12-1.

Synopsis: Guaranteed individual health coverage. Repeals the law concerning the Indiana comprehensive health insurance association (ICHIA). Replaces the ICHIA law with a law under which an accident and sickness insurer or health maintenance organization that provides coverage for basic health care services in Indiana is required to provide coverage as well to certain qualified individuals under an individual health benefit plan at a rate not to exceed 150% of the average health benefit plan premium charged in the previous calendar year. Makes conforming amendments. Makes a technical change.

Effective: Upon passage.

Fry

January 21, 2003, read first time and referred to Committee on Insurance, Corporations and Small Business.

Introduced

First Regular Session 113th General Assembly (2003)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2002 Regular or Special Session of the General Assembly.

HOUSE BILL No. 1749

A BILL FOR AN ACT to amend the Indiana Code concerning insurance.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 2-5-23-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: **Sec. 2.5. As used in this chapter, "health care facility" means any institution providing health care services that is licensed in Indiana, including institutions primarily engaged in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, injury, deformity, or physical condition, including a general hospital, a special hospital, a mental hospital, a public health center, a diagnostic center, a treatment center, a rehabilitation center, an extended care facility, a skilled nursing home, a nursing home, an intermediate care facility, a tuberculosis hospital, a chronic disease hospital, a maternity hospital, an outpatient clinic, a home health care agency, a bioanalytical laboratory, or a central services facility servicing one (1) or more such institutions.**

SECTION 2. IC 2-5-23-8 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8. ~~Beginning May 1, 1997,~~ The

health policy advisory committee is established. At the request of the chairman, the health policy advisory committee shall provide information and otherwise assist the commission to perform the duties of the commission under this chapter. The health policy advisory committee members are ex officio and may not vote. The health policy advisory committee members shall be appointed from the general public and must include one (1) individual who represents each of the following:

(1) The interests of public hospitals.

(2) The interests of community mental health centers.

(3) The interests of community health centers.

(4) The interests of the long term care industry.

(5) The interests of health care professionals licensed under IC 25, but not licensed under IC 25-22.5.

(6) The interests of rural hospitals. An individual appointed under this subdivision must be licensed under IC 25-22.5.

(7) The interests of health maintenance organizations (as defined in IC 27-13-1-19).

(8) The interests of for-profit health care facilities (as defined in ~~IC 27-8-10-1(1)~~ **IC 2-5-23-2.5).**

(9) A statewide consumer organization.

(10) A statewide senior citizen organization.

(11) A statewide organization representing people with disabilities.

(12) Organized labor.

(13) The interests of businesses that purchase health insurance policies.

(14) The interests of businesses that provide employee welfare benefit plans (as defined in 29 U.S.C. 1002) that are self-funded.

(15) A minority community.

(16) The uninsured. An individual appointed under this subdivision must be and must have been chronically uninsured.

(17) An individual who is not associated with any organization, business, or profession represented in this subsection other than as a consumer.

SECTION 3. IC 5-10-8-8.1, AS AMENDED BY P.L.13-2001, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 8.1. (a) This section applies only to the state and former legislators.

(b) As used in this section, "legislator" means a member of the general assembly.

(c) After June 30, 1988, the state shall provide to each retired

legislator:

(1) whose retirement date is after June 30, 1988;

(2) who is not participating in a group health insurance coverage plan:

(A) including Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.; but

(B) not including a group health insurance plan provided by the state; ~~or a health insurance plan provided under IC 27-8-10;~~

(3) who served as a legislator for at least ten (10) years; and

(4) who participated in a group health insurance plan provided by the state on the legislator's retirement date;

a group health insurance program that is equal to that offered active employees.

(d) A retired legislator who qualifies under subsection (c) may participate in the group health insurance program if the retired legislator:

(1) pays an amount equal to the employer's and employee's premium for the group health insurance for an active employee; and

(2) within ninety (90) days after the legislator's retirement date files a written request for insurance coverage with the employer.

(e) Except as provided in section 8(j) of this chapter, a retired legislator's eligibility to continue insurance under this section ends when the member becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq., or when the employer terminates the health insurance program.

(f) A retired legislator who is eligible for insurance coverage under this section may elect to have the legislator's spouse covered under the health insurance program at the time the legislator retires. If a retired legislator's spouse pays the amount the retired legislator would have been required to pay for coverage selected by the spouse, the spouse's subsequent eligibility to continue insurance under this section is not affected by the death of the retired legislator and is not affected by the retired legislator's eligibility for Medicare. Except as provided in section 8(j) of this chapter, the spouse's eligibility ends on the earliest of the following:

(1) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

(2) When the employer terminates the health insurance program.

(3) The date of the spouse's remarriage.

(g) The surviving spouse of a legislator who dies or has died in

office may elect to participate in the group health insurance program if all of the following apply:

(1) The deceased legislator would have been eligible to participate in the group health insurance program under this section had the legislator retired on the day of the legislator's death.

(2) The surviving spouse files a written request for insurance coverage with the employer.

(3) The surviving spouse pays an amount equal to the employer's and employee's premium for the group health insurance for an active employee.

(h) Except as provided in section 8(j) of this chapter, the eligibility of the surviving spouse of a legislator to purchase group health insurance under subsection (g) ends on the earliest of the following:

(1) When the employer terminates the health insurance program.

(2) The date of the spouse's remarriage.

(3) When the spouse becomes eligible for Medicare coverage as prescribed by 42 U.S.C. 1395 et seq.

SECTION 4. IC 27-8-8-2 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 2. (a) As used in this chapter:

"Account" means one of the three (3) accounts created under section 3 of this chapter.

"Association" means the Indiana life and health insurance guaranty association created under section 3 of this chapter.

"Commissioner" refers to the commissioner of insurance.

"Contractual obligation" means an obligation under covered policies.

"Covered policy" means any policy or contract that is of a type described in section 1(a) of this chapter and is not excluded by section 1(b) of this chapter.

"Impaired insurer" means a member insurer deemed by the commissioner to be potentially unable to fulfill its contractual obligations.

"Insolvent insurer" means a member insurer who becomes insolvent and is placed under a final order of liquidation, rehabilitation, or conservation by a court.

"Member insurer" means any person that is licensed or holds a certificate of authority to transact in Indiana any kind of insurance for which coverage is provided under this chapter. The term includes any insurer whose license or certificate of authority to transact such insurance in Indiana may have been suspended, revoked, not renewed, or voluntarily withdrawn but does not include the following:

(1) A medical and hospital service organization.

(2) A health maintenance organization under IC 27-13.

(3) A fraternal benefit society under IC 27-11.

(4) ~~The Indiana Comprehensive Health Insurance Association or any other~~ **A** mandatory state pooling plan or arrangement.

(5) An assessment company or any other person that operates an assessment plan (as defined in IC 27-1-2-3(y)).

(6) An interinsurance exchange authorized by IC 27-6-6.

(7) A prepaid limited health service organization or a limited service health maintenance organization under IC 27-13-34.

~~(8) A special service health care delivery plan under IC 27-8-7.~~

~~(9)~~ **(8)** A farmer's mutual insurance company under IC 27-5.

~~(10)~~ **(9)** Any person similar to any person described in subdivisions (1) through ~~(9).~~ **(8).**

"Premiums" means direct gross insurance premiums and annuity considerations received on covered policies, less return premiums and considerations, and dividends paid or credited to policyholders on direct business. It does not include premiums and considerations on contracts between insurers and reinsurers. For purposes of assessments made under section 6 of this chapter, "premiums" for covered policies shall not be reduced on account of any limitation on benefits for which the association is obligated under section 5(l) of this chapter. However, "premiums" for assessment purposes does not include that portion of any premium exceeding five million dollars ($5,000,000) for any one (1) unallocated annuity contract.

"Person" means any natural person, corporation, limited liability company, partnership, association, voluntary organization, trust, governmental organization or entity, or other business organization or entity.

"Resident" means any person who resides in Indiana at the time the association becomes obligated for an impaired or insolvent insurer. Persons other than natural persons are considered to reside in the state where their principal place of business is located.

"Unallocated annuity contract" means an annuity contract or group annuity certificate that is not issued to and held by a natural person (excluding a natural person acting as a trustee), except to the extent of any annuity benefits guaranteed to a natural person by an insurer under the contract or certificate. For the purposes of section 1.5 of this chapter, an unallocated annuity contract shall not be considered a group covered policy.

(b) For purposes of this chapter, a policy, contract, or certificate is considered to be held by the person identified on the policy, contract,

or certificate as the holder or owner of the policy, contract, or certificate.

SECTION 5. IC 27-8-10.1 IS ADDED TO THE INDIANA CODE AS A **NEW** CHAPTER TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]:

Chapter 10.1. Guaranteed Individual Health Benefit Plan Coverage

Sec. 1. As used in this chapter, "accident and sickness insurer" means an insurer that provides coverage for basic health care services under a policy of accident and sickness insurance.

Sec. 2. As used in this chapter, "actively market" means to offer a health benefit plan to an individual who does not currently receive benefits under the health benefit plan.

Sec. 3. As used in this chapter, "basic health benefit plan" means a health benefit plan that meets the following requirements:

(1) After a deductible, provides coverage for at least eighty percent (80%) of the cost of medically necessary basic health care services.

(2) Meets the requirements for an individual:

(A) policy of accident and sickness insurance specified in IC 27-8-5; or

(B) contract with a health maintenance organization specified in IC 27-13.

Sec. 4. As used in this chapter, "basic health care services" means the following services:

(1) If health benefit plan coverage is provided under a contract with a health maintenance organization, preventive care.

(2) Inpatient and outpatient hospital and physician care.

(3) Diagnostic laboratory care.

(4) Diagnostic and therapeutic radiological services.

(5) Emergency care.

Sec. 5. As used in this chapter, "church plan" has the meaning set forth in the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(e)).

Sec. 6. As used in this chapter, "creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C. 9801(c)(1)).

Sec. 7. As used in this chapter, "federally eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under this chapter, the total period of creditable

coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:

(A) group health plan;

(B) governmental plan; or

(C) church plan;

or health insurance coverage in connection with any of those plans;

(2) who is not eligible for coverage under:

(A) a group health plan;

(B) Part A or Part B of Title XVIII of the federal Social Security Act; or

(C) a state plan under Title XIX of the federal Social Security Act (or any successor program);

and does not have other health insurance coverage;

(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and

(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

Sec. 8. As used in this chapter, "governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

Sec. 9. As used in this chapter, "health benefit plan" means coverage of basic health care services under a:

(1) policy of accident and sickness insurance; or

(2) contract with a health maintenance organization.

Sec. 10. As used in this chapter, "health benefit plan provider" means:

(1) an accident and sickness insurer; or

(2) a health maintenance organization;

that provides coverage under a health benefit plan.

Sec. 11. As used in this chapter, "health maintenance organization" has the meaning set forth in IC 27-13-1-19.

Sec. 12. As used in this chapter, "individual contract" has the meaning set forth in IC 27-13-1-21.

Sec. 13. As used in this chapter, "individual health benefit plan" means a health benefit plan that is:

(1) issued on an individual basis; or

(2) entered into as an individual contract;

and may include coverage of dependents of the individual.

Sec. 14. As used in this chapter, "policy of accident and sickness insurance" has the meaning set forth in IC 27-8-5-1(a).

Sec. 15. As used in this chapter, "qualified individual" means an individual who meets one (1) of the following criteria:

(1) At the effective date of coverage, the individual is not eligible for coverage:

(A) under a group health benefit plan that provides coverage for basic health care services;

(B) under Part A or Part B of Title XVIII of the federal Social Security Act;

(C) under a state plan under Title XIX of the federal Social Security Act (or any successor program); or

(D) available through an employer plan that provides coverage for basic health care services.

(2) The individual is a federally eligible individual.

For purposes of this section, an individual may be a qualified individual if the individual is eligible for Medicare coverage and is less than sixty-five (65) years of age.

Sec. 16. As used in this chapter, "standard health benefit plan" means a health benefit plan that meets the following requirements:

(1) After a deductible, provides coverage for at least eighty percent (80%) of the cost of the following medically necessary services:

(A) Basic health care services.

(B) Mental health services.

(C) Services for alcohol and drug abuse.

(D) Dental services.

(E) Vision services.

(F) Long term rehabilitation treatment.

(2) Meets the requirements for an individual:

(A) policy of accident and sickness insurance specified in IC 27-8-5; or

(B) contract with a health maintenance organization specified in IC 27-13.

Sec. 17. (a) A health benefit plan provider that provides coverage in Indiana under at least one (1) individual health benefit plan shall actively offer to provide coverage to a qualified

individual under all health benefit plans the health benefit plan provider actively markets to individuals in Indiana, including at least:

(1) one (1) basic health benefit plan; and

(2) one (1) standard health benefit plan.

(b) A health benefit plan provider shall provide coverage to a qualified individual under the health benefit plan for which the qualified individual applies.

Sec. 18. A health benefit plan provider may not impose a preexisting condition limitation or exclusion on individual health benefit plan coverage provided under section 17 of this chapter.

Sec. 19. (a) Premiums for individual basic health benefit plan coverage provided under section 17 of this chapter may not exceed one hundred fifty percent (150%) of the average premium charged by health benefit plan providers for basic health benefit plan coverage in Indiana during the previous calendar year, as determined by the department under section 20(a) of this chapter.

(b) Premiums for individual standard health benefit plan coverage provided under section 17 of this chapter may not exceed one hundred fifty percent (150%) of the average premium charged by health benefit plan providers for standard health benefit plan coverage in Indiana during the previous calendar year, as determined by the department under section 20(b) of this chapter.

Sec. 20. (a) The department shall calculate and make available to health benefit plan providers the average premium charged for basic health benefit plan coverage as reported to the department under IC 27-1-22 by the five (5) health benefit plan providers with the largest premium volume in Indiana during the previous calendar year.

(b) The department shall calculate and make available to health benefit plan providers the average premium charged for standard health benefit plan coverage as reported to the department under IC 27-1-22 by the five (5) health benefit plan providers with the largest premium volume in Indiana during the previous calendar year.

Sec. 21. Coverage for basic health care services provided under this chapter shall be provided in compliance with the federal Health Insurance Portability and Accountability Act of 1996 (P.L.104-191).

SECTION 6. IC 27-8-15-28 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 28. (a) As used in this section, "health insurance plan" means coverage provided under

any of the following:

(1) A hospital or medical expense incurred policy or certificate.

(2) A hospital or medical service plan contract.

(3) A health maintenance organization subscriber contract.

(4) Medicare or Medicaid.

(5) An employer based health insurance arrangement.

(6) An individual health insurance policy.

~~(7) A policy issued by the Indiana comprehensive health insurance association under IC 27-8-10.~~

~~(8)~~ **(7)** An employee welfare benefit plan (as defined in 29 U.S.C. 1002) that is self-funded.

~~(9)~~ **(8)** A conversion policy issued under section 31 or 31.1 of this chapter.

(b) Except as provided in section 29 of this chapter, a small employer insurer shall waive the exclusion period described in section 27 of this chapter applicable to a preexisting condition or the limitation period with respect to a particular service in a health insurance plan for the time an eligible employee or a dependent of an eligible employee was previously covered by a health insurance plan if the following conditions are met:

(1) The eligible employee or a dependent of the eligible employee was previously covered by a health insurance plan that provided benefits with respect to the particular service.

(2) Coverage under the health insurance plan was continuous to a date not more than sixty-three (63) days before the effective date of enrollment by:

(A) the eligible employee; or

(B) a dependent of the eligible employee.

(c) In determining whether an eligible employee or a dependent of the eligible employee meets the requirements of subsection (b)(2), a waiting period imposed by a small employer insurer or small employer before new coverage may become effective must be excluded from the calculation.

(d) This section does not preclude the application of any waiting period applicable to all new enrollees under a plan.

SECTION 7. IC 27-13-16-4 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 4. If an enrollee is hospitalized continuously from the date of receivership through the last date of the enrollee's continuation of benefits under section 1 of this chapter, the enrollee shall be eligible for ~~an Indiana comprehensive health insurance policy under IC 27-8-10~~ **individual health benefit plan coverage under IC 27-8-10.1.** Notwithstanding any provision of

~~IC 27-8-10~~, **IC 27-8-10.1,** the policy may not contain preexisting condition exclusions with respect to the condition for which the enrollee was hospitalized. The enrollee shall become eligible for coverage effective on the first day after the enrollee's continuation of benefits ends.

SECTION 8. IC 34-30-12-1, AS AMENDED BY P.L.1-1999, SECTION 73, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE UPON PASSAGE]: Sec. 1. (a) This section does not apply to services rendered by a health care provider (as defined in IC 34-18-2-14 or IC 27-12-2-14 before its repeal) to a patient in a health care facility (as defined in ~~IC 27-8-10-1~~ **IC 2-5-23-2.5**).

(b) Except as provided in subsection (c), a person who comes upon the scene of an emergency or accident or is summoned to the scene of an emergency or accident and, in good faith, gratuitously renders emergency care at the scene of the emergency or accident is immune from civil liability for any personal injury that results from:

(1) any act or omission by the person in rendering the emergency care; or

(2) any act or failure to act to provide or arrange for further medical treatment or care for the injured person;

except for acts or omissions amounting to gross negligence or willful or wanton misconduct.

(c) This subsection applies to a person to whom IC 16-31-6.5 applies. A person who gratuitously renders emergency care involving the use of an automatic external defibrillator is immune from liability for any act or omission not amounting to gross negligence or willful or wanton misconduct if the person fulfills the requirements set forth in IC 16-31-6.5.

(d) This subsection applies to an individual, business, or organization to which IC 16-31-6.5 applies. An individual, business, or organization that allows a person who is an expected user to use an automatic external defibrillator of the individual, business, or organization to in good faith gratuitously render emergency care is immune from civil liability for any damages resulting from an act or omission not amounting to gross negligence or willful or wanton misconduct by the user or for acquiring or providing the automatic external defibrillator to the user for the purpose of rendering the emergency care if the individual, business, or organization and the user fulfill the requirements set forth in IC 16-31-6.5.

SECTION 9. THE FOLLOWING ARE REPEALED [EFFECTIVE UPON PASSAGE]: IC 27-8-10; IC 34-30-2-116.

SECTION 10. **An emergency is declared for this act.**